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CURRENT DEVELOPMENTS IN PROSPECTIVE REIMBURSEMENT SYSTEMS FOR FINANCING HOSPITAL CARE [1]

EXECUTIVE SUMMARY

State ratesetting programs have, at least in some cases, been effective in reducing the rate of growth in hospital expenditures. For example, the national growth in average annual per capita hospital costs between 1976 and 1980 was 13.8 percent per year. In contrast, seven States with mandatory ratesetting programs had an average annual per capita increase of 10.5 percent—a 25-percent reduction in the rate of increase.

These States and their annual average rates of increase in per capita hospital costs between 1976 and 1980 include: Connecticut, 11.2 percent; Maryland, 13.2 percent; Massachusetts, 11.4 percent; New Jersey, 11.8 percent; New York, 9.1 percent; Washington, 10.9 percent; Wisconsin, 12.5 percent.[2]

A majority of States now have prospective payment systems for at least one payer in operation. Using such devices as revenue caps, rate and budget review, DRG's, price competition, and primary care networks, State governments are actively seeking reasonable and affordable prices for hospital care.

The trend toward prospective payment systems includes a variety of new and creative State and local programs developed, and in some cases implemented over the last year. Leading examples of these innovative approaches to hospital cost containment include:

—*Arizona.* Under the Arizona health care cost-containment system—AHCCCS (pronounced "ACCESS")—the State and participating private employers use a broker to contract with case managers to provide care on a prepaid, per capita basis.

—*California.* The State negotiates with each hospital willing to treat medicaid patients and then signs contracts with those hospitals that meet Medi-Cal requirements for care at the lowest price. Also, private third-party payers are authorized to contract with "preferred providers"—hospitals and physicians—at a discounted rate and to offer policyholders significant reductions in premiums if the insured choose to receive all care through contracted providers.

—*Massachusetts.* In legislation enacted in 1983, a revenue "cap" is placed on each hospital that limits the amount of revenue to be paid to the hospital over a fiscal year. In addition, the al-

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[1] Prepared by Donald L. Zimmerman, Ph. D., for the Intergovernmental Health Policy Project, George Washington University, Richard E. Merritt, director. This paper significantly revises, updates, and enlarges a June 22, 1982, report prepared by the staff of the Subcommittee on Health, Senate Finance Committee (with assistance of Janet Pernice Lundy and Glenn Markus of the Congressional Research Service), entitled, "Prospective Reimbursement of Hospitals."

[2] These estimates of program effectiveness are calculations made by ICF, Inc., from census data made available in June 1982.

lowable projected increase in hospital revenues will be reduced by 7.5 percent over the next 6 years.

—*New York.* In 1983, the State enacted a total revenue cap on each hospital and created common "pools" of third-party funds to reimburse hospitals that are financially strained by patient bad debt and charity care.

In light of the increasing commitment of State governments to new cost-containment strategies, several questions are raised:

—Do these programs maintain an appropriate balance between reduced costs and quality of care?

—Are successful State programs transferable to other States?

—Are these programs appropriate models for a national "all-payer" system?

—What is the impact of hospital ratesetting programs on physicians and other providers?

—What is the fiscal impact of hospital ratesetting or other segments of the health economy?

These questions are not easily answered. But because of immediate fiscal pressures, an increasing number of States are operating and developing payment systems that seek to establish a fixed purchase price for hospital services. This paper presents a framework for understanding the many different State prospective systems now in operation. In addition, a number of key State systems are described and recent innovations are reviewed.

A. INTRODUCTION

Since the mid-1960's, hospital cost increases have consistently outpaced the Consumer Price Index (CPI), rising at an average annual rate of 13 percent. From 1965 to 1981, expenditures for hospital care grew by roughly 750 percent (from $14 to $118 billion). In 1965, the average cost of a day of hospital care was $41; by 1981, that cost had reached $229. During 1982, when the rate of inflation was only 5 percent, hospital costs grew more than twice that fast.

In response to dramatic cost increases, many policymakers have proposed a variety of cost-containment strategies. Such initiatives have traditionally targeted reductions in eligibility, restriction of services, increased copayments and deductibles, and peer utilization review. Although these efforts to control costs have had some short-term success, their cumulative impact has created only minor deviations in the overall rate of increase for hospital costs.

While there are a number of factors that contribute to the upward spiral of hospital costs, the primary mechanism driving hospital expenditures is the *cost-based retrospective reimbursement methodology* used historically by the public and private sectors to pay for hospital services. Recognizing the inherently inflationary nature of retrospective reimbursement, many programs have been adopted to alter the basic method for paying for hospital care by replacing it with alternative *prospective reimbursement systems.*

Generically, prospective reimbursement systems move the focus of pricing power from individual hospitals to an external authority that establishes fixed-dollar limits for payments to hospitals. These dollar limits are established prior to the time period in which the care is actually provided, forcing hospitals to contain costs within the fiscal constraints of the set price.

The introduction of fixed prospective payment rates severs the direct link which exists in retrospective reimbursement between the cost of services provided to patients by a hospital and the amount paid to the hospital by third-party payers. Under a fixed-rate program, if a hospital's costs exceed the established payment rates, the hospital will face a real dollar loss. The possibility of noncompensated care thus creates an incentive for hospitals to be more cost conscious and efficient.

A primary example of a prospective payment strategy is the recent Federal decision to introduce fixed dollar rates for different types of diagnostic related groups (DRG's) in the medicare program. But the price constraint imposed on medicare costs will not, alone, resolve the overall problem of hospital cost increases.

With only medicare reimbursement under a fixed-price prospective system, hospitals may shift the medicare revenue costs that exceed their other payers. This possibility is significantly reduced in many States by new and important approaches to the full containment of hospital costs.

B. OVERVIEW OF PROSPECTIVE REIMBURSEMENT SYSTEMS

1. Background

The factors impelling the creation of prospective payment programs have varied almost as much as the systems themselves. Some programs were the result of unbridled increases in medicaid budgets and dwindling State revenues; others were influenced by alarming increases in health insurance premiums and hikes in employer contributions for employee benefits; in still others, the growing tide of cost shifting among third-party payers was important; and, in a few, the threat of Blue Cross insolvency was paramount. Cutting across these forces, however, were some significant modifications in Federal policy which fostered experiments and demonstrations with prospective reimbursement.

As early as 1967, Congress authorized payment experiments to search for strategies to contain hospital costs; however, very few alternative experiments evolved. In 1972, Congress expanded HEW's authority to experiment with prospective and other alternative reimbursement systems for medicare and medicaid. Under this authority, HEW provided development and demonstration funds to test the efficiency and effectiveness of a number of alternatives. In 1974 and 1978, HEW supported evaluations of several such systems. Moreover, in 1974, as part of the National Health Planning Act, Congress reaffirmed its interest in prospective reimbursement and funded six State hospital ratesetting demonstration programs.

Hence, by the end of 1976, about 20 prospective reimbursement systems were underway, most of which were initiated and administered by Blue Cross plans or hospital associations. Eleven programs, however, were the result of State legislation. In 3 of the 11 State-legislated programs, commissions were created to perform the ratesetting function; in the remaining States, the authority rested with a public agency, usually the health department.

The Omnibus Budget Reconciliation Act of 1981 (section 2173) encouraged State development of prospective payment systems. This key section allows States to replace medicaid reimbursement systems based on retrospective cost-based medicare principles with systems that set rates adequate to meet the cost of "efficiently and economically operated facilities."

By the summer of 1983, prospective ratesetting programs were in operation in 26 States—all aimed at establishing a reasonable price for quality hospital care.

Current State efforts to control hospital costs through prospectively determined rates and payments comprise a mosaic of strategies and program designs.

2. The Basic Framework of State Programs

(A) TYPE OF ADMINISTRATIVE BODY RESPONSIBLE FOR THE PROGRAM

There is considerable variation in the definition of the "external authority" responsible for operating the prospective ratesetting program. Key variations include: (1) How the authority is established—it might be created by specific legislative action, independent activities of private insurers, local decisionmaking bodies, or coalitions of business, labor, and consumer groups; (2) how the authority is organized—it may take the form of a temporary or permanent commission, government agency, community board, or in one particular case, a legislatively mandated office of health care negotiations led by a "czar"; and (3) how the authority is staffed—it may include volunteer representatives of all involved parties, a full-time professional staff recruited from the private sector, or a reorganized component of a standing State administrative unit.

(B) TYPES OF RISKS AND INCENTIVES INTRODUCED

A fundamental goal of a prospective reimbursement system is to compel hospitals to bear a greater degree of financial risk than that encountered when paid on a retrospective cost or charge basis. The basic "risk" created by prospective payment systems forces hospitals to provide care at a previously agreed-upon price. The hospital is "at-risk" for all costs exceeding the established price. This type of risk creates the incentive for hospital managers concerned with the fiscal solvency of their hospitals to implement new "cost conscious" medical and administrative practices that insure adequate payment for the services rendered to the patient.

In addition to such negative incentives, many prospective payment programs use positive incentives to encourage cost containment. One of the most basic incentives permits institutions to retain, as profit, some or all of any dollar difference between incurred costs that are less than the prospective payment amounts. Such an incentive may not always contribute successfully to cost containment in systems that base future payment determinations on the present cost experience. It is quite possible that hospitals may be encouraged to keep their expenses as close to the prospective rate as possible in order to preserve a high base from which any calculations are made.

(C) MANDATORY VERSUS VOLUNTARY HOSPITAL PARTICIPATION

Some studies of prospective payment systems suggest that mandatory participation by hospitals is an essential ingredient of an effective system. Mandatory programs are those with legal authority to require hospitals' participation and to force hospitals to comply with program rulings. Prospective systems may be made mandatory by statute for all third-party purchasers of care to create an all-payers system. Alternatively, the mandatory nature of the program may extend only to services reimbursed by specific governmental programs of private third-party purchasers. Voluntary programs are those in which either hospital participation or compliance, or both, is left to the discretion of the institutions. Both man-

datory and voluntary programs may apply to one, multiple, or all payers.

(D) STRINGENCY OF THE PAYMENT RATES

A stringent rate is one that requires hospital management to exercise considerable skill and operating efficiency to provide services at the established price. Since hospitals that fail to keep costs under their price are likely to face financial difficulties, rates set too low can raise special problems.

Cost shifting to other third-party payers is a potential consequence when fewer than all third-party payers are involved. In situations where only one third-party payer has established a fixed-rate payment program, hospitals may find it advantageous to shift costs in excess of the fixed amount to other payers. Because of different financial requirements of different types of hospitals (i.e., profit, teaching, community, public), the potential for shifting of costs is greatest in hospitals with significant revenues from a variety of third-party payers. In contrast, financially marginal hospitals and hospitals that serve a high proportion of publicly financed beneficiaries and uninsured patients may require special allowances if they are to continue providing care.

(E) EQUITY OF THE SYSTEM

A key characteristic of different prospective payment systems is the method used to equitably balance the total aggregate dollar amount to be paid to hospitals over the next fiscal term with the particular financial strains a given hospital may experience as a result of the impact of cost-related factors out of the hospital's direct control. For example, specific hospitals may be faced with an unexpected and dramatic increase in the rate and incidence of a specific type of illness through an epidemic. Or a financially distressed urban hospital serving a disproportionate number of publicly supported patients may require special assistance to insure adequate beneficiary access. A regional teaching facility may require additional supplementary funds to continue providing medical education.

Methods for determining the legitimate criteria for differentiating the amount to be paid to different hospitals in a fair and equitable fashion are quite varied. Examples include: (a) Setting different rates for different groups of hospitals sharing similar characteristics; (b) authorizing additional payments to a hospital providing care to patients requiring extraordinary and unusually expensive care; and (c) creating a dollar pool above the prospective rate that can be used to pay for special costs incurred by a given hospital because of "special circumstances."

3. Prospective Payment Mechanisms

At the heart of each alternative prospective payment system is the mechanism for determining the actual dollars to be spent for hospital services. At a minimum, attention must be given to the following components: (a) Determination of the unit of payment; (b)

scope of revenue subject to the perspective system; (c) establishing the rate; and (d) reviewing and modifying established rule.

(A) DETERMINATION OF THE UNIT OF PAYMENT

Prospective payments are made on the basis of hospital cost performance as measured by specific units of payment, which may include the total hospital budget, separate department budgets, direct medical and indirect administrative costs, actuarially defined costs per subpopulation, type of diagnosis, length of stay, average per diem costs, and units of service produced. Different units of payment can produce different kinds of hospital responses in order to keep costs below the prospective payment rates. For example, prospective systems that control a hospital's total revenues, rather than establish per diem or per case payment rates, create less incentive for the hospital to try to circumvent the cost-control system by increasing admissions or lengths of stay. Payment units based on per case, per diem, or specific services are all open to circumvention by increases in volume. In addition, if such units are used, extensive utilization controls may be necessary in order to insure that only the needed quantity of care is provided. The use of total revenue caps or capitated reimbursement strategies may motivate hospitals to reduce the quantity (admissions and patient days) and the unit costs of services (through changes in case mix or reductions in scope of service).

(B) SCOPE OF REVENUE SUBJECT TO THE PROSPECTIVE SYSTEM

Much of the discussion about prospective payment systems focuses on the scope of the revenues subject to the incentives contained in such systems. As a general rule, all-payer systems that prospectively determine all hospital revenue will have a more significant impact on hospital expenditures than single or partial payer programs, because the greater proportion of hospital revenues controlled, the more the cost-containment potential of the prospective system is increased. A common fear expressed about such unilateral payment systems is that a centralized regulatory environment may be created that may not recognize the legitimate fiscal needs of hospitals for meeting future contingencies such as the purchase price of new technology, increased demands by physicians, and requests to create new community "outreach" programs.

(C) ESTABLISHING THE RATE

One of the basic components of a prospective reimbursement program is the method used for establishing the actual rate to be paid for hospital care.

Although there are a variety of practical methods currently used, four general methods can be identified. *Direct negotiation* typically involves direct contact between the ratesetting organization and either individual hospitals or their collective representatives. In general, hospitals present their financial requirements and ratesetters challenge these needs on the basis of designated target rates. Bargaining over payment amounts often provides the opportunity

for the ratesetters to consider the circumstances and requirements of individual facilities.

The negotiation approach can require extensive administrative effort when applied to large numbers of institutions or to widely diverse hospital facilities. The relative skills of the respective ratesetters, rather than clear objective factors, can also play a major role in determining the actual prices paid.

The *bidding approach* involves the solicitation of bids from hospitals prior to the payment period. The purchasers of services select the lowest bid or establish criteria for evaluating the submitted bids. Although the bidding approach reflects market-based assumptions, since price competition among hospitals may be weak in a given market, securing meaningful cost-containing bids in this manner may be impractical. This is particularly true if hospitals are unwilling to participate or compete with each other by offering different price and service packages.

Under the *budget review and approval* approach, the rate-determining authority or agency periodically examines the budgets and schedules of individual hospitals and establishes rates according to guidelines prescribed by the authority. The frequency and extent of the review determines the influence this approach may have on hospital costs. The success of the budget review approach typically depends on the extent of good data, technical resources, and the expertise of the budget reviewers in evaluating hospital costs, operations, and accounting procedures.

Setting rates through the *application of a formula* is an approach that varies widely from simple techniques to quite sophisticated methods. One common application of this approach is the calculation of appropriate payment levels for a given hospital based on a projection of the historically averaged costs of care for patients likely to be served by that institution. For example, by determining the "average cost per patient" for the prior year and trending it forward to the coming year with adjustments for such variables as case mix, potential demand, changes in actuarially defined population characteristics, and inflation, estimates of expected costs can be developed. The DRG methodology in the medicare program uses a formula that fixes future prices for different types of medical diagnoses based on an adjusted estimate of the expected costs for each separate diagnostic group.

Another way of using a formula for determining prices is to place each individual hospital into a "peer group" of similar facilities based on a set of key differentiating variables. In this approach, each hospital in a given group is assumed to share common fiscal requirements with all other hospitals in the same group. After calculating an aggregate measure of costs for each group for the prior year and adjusting it to reflect probable changes, the same prospective rate is applied to each hospital in each separate group.

These four approaches to setting prospective rates are not mutually exclusive. Many of the programs currently in place combine elements from each of the methods. For example, formulae are often found with budget review and approval approaches that set overall financial ceilings, and direct negotiation is often a part of the bidding approach.

(D) REVIEWING AND MODIFYING THE ESTABLISHED RATE

Several different techniques are used to review and modify prospective hospital payment rates. Some involve an examination of the internal cost history and past trends within a single hospital. Others involve comparative examinations of groups of similarly situated hospitals. Such reviews may be based on an examination of the use of cost screens or statistical analyses, the examination of specific operating procedures, financial data, or the simultaneous review of budget and cost reports.

Other guidelines are used to evaluate proposed increases or to modify previously established rates, such as imposition of legislatively determined ceilings or variable rates of increase based on external economic factors (e.g., consumer or market-basket indices) and internal factors (e.g., case mix, bed size, etc.).

Although not exhaustive, this brief framework for describing prospective payment systems highlights a number of variables that should be considered in the evaluation of current State initiatives to contain hospital costs.

C. DESCRIPTION OF SELECTED STATE PROSPECTIVE REIMBURSEMENT SYSTEMS

The following brief descriptions of State initiatives to control hospital costs through prospective payment systems provide a basic orientation to the variety of cost-containment options currently being explored by State governments as well as private insurers. Recently enacted programs are described in detail. The existing programs selected for description demonstrate the diversity of program alternatives and State activities.

1. ARIZONA

Arizona has recently established a unique and potentially dramatic approach to publicly financed health care. Starting in 1981, the Arizona health care cost containment system (AHCCCS) has combined several innovative concepts with a prospective payment system including:

Price competition. Competition is encouraged through the requirement that providers compete for contracts to serve AHCCCS patients in a statewide bidding process. Each provider winning a contract must then compete for patients in each local area with more than one contractor.

Case management. As a means to control utilization, each contracting provider is placed at financial risk for providing and/or authorizing access to all other services required or desired by an enrolled member.

Expanded purchasing power of Government. AHCCCS, in distinction to other State medicaid programs, covers State and county government employees, employees without subsidy, in addition to the low-income population. Thus, the Arizona program has attempted to enlarge the purchasing power of government beyond the scope defined by Federal health programs to include significant subpopulations traditionally served by private sector third-party payers.

Driving the entire program is a prospective payment system that pays contractors a fixed monthly capitated dollar amount for each AHCCCS member served by a given case manager. These dollars must pay for all services, including hospitalization, lab work, and drugs. If funds are left over, the contracting provider can realize a profit; however, if costs exceed this amount, the contractor suffers a loss. To prevent providers from minimizing care in the hope of generating inappropriate levels of profit, there is a quality control system that includes medical interviews, site visits, audits, and a grievance procedure.

In addition to the risk incurred by individual providers, the State also assumes risk by entering into a prospective payment arrangement with the Federal Government. Under this arrangement, the

amount of Federal matching funds for Arizona's medicaid program is set at 95 percent of the funds that would be paid to the State *if* it had a more traditional medicaid program.

2. California

One of the more unique methods for containing hospital costs was enacted into law in California through AB 799, SB 2012, and AB 3480, as the Medi-Cal reform legislation of 1982. In this legislation, California lawmakers took the following steps to introduce market-based reforms into the purchase and delivery systems of health care services:

First. Authorized the creation, effective July 1, 1982, of a 1-year position in the office of the Governor of a special hospital negotiator to act as a prudent purchaser of all inpatient hospital services for the Medi-Cal population by contracting with the most price-competitive facilities. On July 1, 1983, the functions, powers, and duties of the special hospital negotiator (the office of special health care negotiations) were transferred to a newly created California Medical Assistance Commission with the executive director serving as chief negotiator.

Second. Authorized the Department of Health Services (beginning July 1, 1983) to enter into selective contracts with noninstitutional providers for services to the Medi-Cal population. (Potentially, contracts with noninstitutional providers could be negotiated through the Medical Assistance Commission or with the Department of Health Services.)

Third. Authorized private insurance companies and nonprofit hospital plans (i.e., Blue Cross) to contract with preferred providers and to create a set of economic incentives for consumers to restrict their choice of providers to those under contract. This authority became effective January 1, 1983, for hospitals, and July 1, 1983, for physicians.

These three reforms are intended to create two major changes in the marketplace for medical services in coming years. The first and most basic reform is the authorization of contracting for Medi-Cal hospital services. This mechanism is intended to create a new administrative role of the *prudent purchaser* that combines complete and full knowledge of both the sellers' and consumers' needs into a single decisionmaking process (i.e., the special hospital negotiator and the Medical Assistance Commission). The informed purchasing of hospital services for the Medi-Cal population is restrained by available dollars allocated by the State legislature and by State and Federal law specifying the minimum set of services to be purchased. Thus, the prudent purchaser is responsible for buying the most price-competitive services available in the medical marketplace for meeting the legislatively defined needs of the Medi-Cal consumer. As a result, it is assumed that provider knowledge of the State's fiscal constraints and buying needs will induce price competition among providers wishing to sell their services to the State. Each hospital under contract will be prospectively limited to a fixed per diem rate.

The second important reform is the authorization of private health insurance companies to contract with preferred providers

and to direct their policyholders to these providers for medical care. This reform is intended to have two direct consequences. First, it is intended to inhibit cost shifting to private payers that could result from the selective contracting of Medi-Cal services. (For example, it was estimated that the negotiated purchasing of Medi-Cal services could, without suitable offsetting *legislation,* create a shift of more than $800 million to other third-party payers.) Second, because private insurance companies can deliver a captive population of policyholders, it is assumed that providers will compete for access to medical business by offering a discount in current market prices to major third-party purchasers. It is expected that private insurance companies will pass the reductions in provider costs along to consumers by way of reduced premiums. In so doing, the costs of private insurance should decrease as companies compete for new customers by offering more cost-attractive plans.

Taken together, the California system is intended to change the medical marketplace from one where providers determine both the cost of services and the population served, to one where the State and private insurers define both the available dollars for health care and also the providers who may receive these dollars.

3. Connecticut

Long in the ratesetting business, the Connecticut Commission on Hospitals and Health Care annually reviews and approves hospital capital expenditures budgets. Participation and compliance by all nongovernment hospitals in budget and rate review is mandatory. The program covers charge-based payers directly, and other payers indirectly, through total budget controls.

Previously, the commission would review each hospital's proposed budget for inpatient revenues based on an overall test of reasonableness. Hospitals failing this test were subjected to detailed regulatory review and modification. However, recent legislation has modified this approach by replacing the test for reasonableness by a less stringent "superscreen." The superscreen is based on the Health Care Financing Administration's estimated inflation rate for Connecticut hospitals, plus 2 percent to account for increases in volume and service intensity. If a hospital's proposed budget is less than the superscreen allowance, it is excluded from further review. If the budget exceeds the screen, the review continues as in previous years.

By moving to a system where detailed budget review is used only for hospitals exceeding higher fiscal screens, the recent modifications in Connecticut are likely to decrease the effectiveness of its cost-containment program.

4. Maryland

One of the first States to establish a prospective hospital payment system, the Maryland Health Services Cost Review Commission sets and reviews rates for all non-Federal acute short-term general hospitals and all nongovernment long-term and specialty hospitals in the State. The program covers all payers and is waived

from the implementation of the Federal DRG methodology for the medicare program.

In this program, detailed budget reviews of each hospital are initially used to establish a set of rates. In subsequent years, automatic adjustments for inflation, volume, case mix, and certain pass-through costs are applied. A hospital may, however, request a detailed budget review instead, which uses comparisons of costs across similar hospitals. In addition, the guaranteed inpatient revenue system (GIR) is used for all hospitals in excess of 400 beds and any other hospital wishing to participate. The GIR system applies DRG-determined payment rates to each case serviced by a given hospital. The hospital is at risk for any saving or loss realized under the system.

5. Massachusetts

The recently enacted "chapter 372" system places prospectively determined *caps* on hospital revenue from all payers. These caps place a strict limitation on the total amount of dollars to be paid to hospitals. Hospitals that keep costs below their revenue limit can keep the balance as discretionary profit; if the limit is exceeded, the amount in excess of the cap must be absorbed by the hospital as loss.

In determining the actual dollar limit to be used as the cap, all hospital revenues are to be reduced by a cumulative 7.5 percent over the next 6 years. The cap is calculated for each hospital on the basis of the previous year's State-approved revenue limitation. If volume exceeds the previous year's by more than 4 percent, hospitals will be reimbursed for ancillary services at rates below the marginal costs. Such disincentives to increasing volume are complemented by incentives to reduce volume: Hospitals are allowed a 7-percent decrease of inpatient days without losing any revenues. The formula for calculating revenue limits also recognizes legitimate cost increases due to inflation, changes in service volume, and certain exceptional circumstances. The calculation, however, specifically excludes the fiscal impact of changes in the severity or intensity of services required by patients. The exclusion of the severity and intensity variable is intended to minimize any incentive for a hospital to engage in "preferred selection" of patients requiring cost-effective care over cases requiring more complex and costly services.

6. New Jersey

Under the New Jersey system, a hospital ratesetting commission was established to approve and adjust hospital rates based on diagnosis related groups (DRG's). Participation and compliance by all short-term acute hospitals is mandatory. The program covers all third-party payers, including medicare through a specific waiver.

The case mix system in effect in New Jersey was used as the model for the national DRG medicare methodology. Briefly, it establishes a per case rate of payment specific to approximately 450 diagnostic groups. The dollar rate for each DRG is developed from base year costs derived from medical discharge abstracts, patient billing records, and hospital financial and statistical uniform re-

ports. Adjustments to the base DRG payment rate for direct costs are made for local and regional variations in wages, an "economic factor" for inflation, and patient volume. Indirect administrative costs are considered fixed and not subject to variation because of changes in case mix or volume. At the end of the rate year, if the revenues collected are over or under the approved revenue budget, they are included in the next year's rates. In this system, prospective rates are established that reflect the differential costs expected to be treated by each hospital in the coming term.

7. New York

The New York prospective hospital reimbursement methodology (NYPHRM) was implemented in January 1983. In this system, prospective cost-based rates are established for all hospitals as a guaranteed revenue cap. Like Massachusetts, this cap places a limit on total revenues available to a hospital from all payers. The revenue cap is determined on the basis of each hospital's 1981 allowable costs, trended forward for inflation and adjusted for changes in volume, case mix, services added or deleted, and reasonable increases in labor costs.

In addition, each hospital's allowable costs are limited to the average cost experienced by its peer group, plus 5 percent. A 7.5-percent "risk corridor" is available to pay hospitals with costs above the group average. In addition, a 1-percent discretionary fund allowance has added to each hospital's 1983 per diem rate.

One of the most innovative aspects of New York's program is its mechanism for providing an allowance for bad debt and charity care. In this system, each hospital payer is required to add a specified dollar amount to its rate that is added to a regional pool and distributed back to hospitals in need of additional funds. Separate pools are established for public hospitals, voluntary nonprofit, and proprietary facilities. Any shortfall created by the medicare share of bad debt will be made up by other third-party payers.

8. Rhode Island

Under Rhode Island's system, the staffs of Blue Cross, the State budget office, and the Rhode Island Hospital Association negotiate an annual "maxicap" that places a limit in the statewide budget for all hospital care for the upcoming year. Participation and compliance by all non-Federal hospitals is mandatory. The program covers Blue Cross and medicaid (medicare participated from 1975 to 1978).

Once the maxicap is established, hospital budgets are reviewed in detail and negotiated with Blue Cross staff. Adjustments are made to the base for inflation, volume changes, and new and expanded services. After total operating expenses are negotiated, the hospital establishes a schedule of charges which is reviewed by Blue Cross and the State budget office. The schedule of charges is then used to establish separate rates for Blue Cross and medicaid by adjusting for cost and benefit differences.

9. Rochester and Finger Lakes, N.Y.

The Health Care Financing Administration has contracted with the Rochester Area Hospitals' Corporation (RAHC) Project and the Finger Lakes Area Hospitals' Corporation (FLAHC) Project to test whether an areawide budget cap is effective in controlling hospital costs. Participation in the project was initially voluntary for the nine RAHC and the eight FLAHC hospitals. All hospitals must now remain in the system for the duration of the demonstration. The programs in both areas directly control payments from medicare, medicaid, Blue Cross, and all other hospital income.

The RAHC and the FLAHC systems are virtually the same, except that RAHC is a test of an areawide budget in a metropolitan area and FLAHC is in a rural area. Both systems operate by determining an overall limit on the yearly pool of revenues for all of the area hospitals. From this pool of revenues, individual hospitals are guaranteed payments equal to their base year costs, adjusted for inflation, increases in volume, and for approved new projects. In addition, a contingency fund equal to about 2 percent of the hospitals' allowable cost basis is established to make payments to hospitals for volume changes, certificate-of-need projects, case-mix adjustments, and other purposes.

The total payments available to each hospital from the common pool of revenues are used to pay *all* operating costs for the year, including outpatient care. Because each hospital is free to allocate its given revenues in its own fashion, this system offers a variety of options to hospital administrators for targeting dollars in cost-efficient ways.

10. Washington

The Washington State Hospital Commission annually reviews and approves hospital budgets. Participation and compliance by all non-Federal hospitals is mandatory. The program covers all charge-based payers.

The commission reviews in detail various cost centers in each hospital's budget annually. Costs which exceed previously defined dollar limits are either disallowed or justified by the hospital. Budgets are analyzed for significant changes in the area, such as new beds, services, and the reasonableness of volume projections. Further reviews are based on a comparison of individual hospital budgets to the budgets of similar hospitals. After capital costs and financial ratios (revenues to expenses) are reviewed in detail, the commission then negotiates the amount of total revenue to be allowed for a given hospital. The hospital establishes its list of charges from the resulting total dollar figure.

In addition to the State systems described above, three additional States have adopted comprehensive hospital cost-containment legislation during the last year that deserves mention.

11. West Virginia

The enacting legislation for the health care cost review authority empowers the review board to initiate reviews and investigations of hospital rates for specific services and the component factors which

determine such rates, as well as total operating budgets. The specific rate-determination criteria require that: (1) The costs of hospital services are reasonably related to services provided, and the rates are reasonably related to the costs; (2) the rates are equitably established among all purchasers with a hospital; (3) medicaid rates are reasonable and adequate to meet the costs incurred by efficiently and economically operated hospitals; and (4) the rates are equitable in comparison to prevailing rates for similar services in similar hospitals.

As an incentive to efficient hospital management, hospitals will be allowed to retain any saving realized under the prospective rate and be partially liable for any resulting deficits.

Until rates are established, all payment limits have been established by freezing hospital revenues at their February 1, 1983, levels plus a 12-percent annual increase.

12. Wisconsin

Wisconsin's new program, which sets *maximum* rates, will go into effect on January 1, 1985. Meanwhile, the commission is directed by law to review and evaluate each hospital's rate request in light of a variety of standards for decisionmaking, including: (1) Comparisons with prudently administered hospitals of similar size or providing similar services that offer quality health care with sufficient staff; (2) the special circumstances of rural hospitals and teaching hospitals; and (3) findings of utilization review program relating to the applicant hospital. In classifying hospitals for purposes of comparison, the commission is directed to consider volume, intensity, educational programs, and special services provided.

Price competition among both physicians and hospitals has been encouraged in this new legislation by allowing major third-party payers to establish preferred provider organizations PPO's. In addition, the legislation introduces the unique requirement that all major employers (over 250 employees) must offer at least two competing health plans to their employees, one of which to be either a PPO or HMO plan.

13. Maine

Maine's commission will be funded by an assessment of up to .15 percent of each hospital's gross patient service revenues. A uniform system for reporting financial and health care information will be required of all hospitals.

The law provides that the commission shall establish a gross patient service revenue limit for each hospital for each payment year beginning October 1, 1984. The statute also directs the commission to exercise its best efforts to design a program which will qualify for a waiver for medicare participation in the State program.

The commission also has the authority to implement experimental or demonstration projects designed to assess methods of establishing revenue limits or payment methodologies other than those established by the statute. The experimental or demonstration projects may include such alternatives as diagnostic related groups, capitation, preferred provider relationships, and regional hospital corporations.

D. RELATED STRATEGIES

In response to the flexibility granted to States through the Omnibus Budget Reconciliation Act (OBRA), a number of important program initiatives are taking place in the medicaid program that link alternative payment systems with new forms of utilization controls through section 2175 waivers. One of the most significant opportunities granted by this section of OBRA allows States to establish systems of utilization control by limiting beneficiary "freedom of choice" through case management and primary care networks. In this approach, primary care physicians generally take medical and financial control and responsibility for the care of a given number of medicaid beneficiaries served.

Beneficiaries cannot receive any medical services without the direct authorization of the primary care physician responsible for their care. Physicians in the primary care network are expected to limit unnecessary beneficiary utilization by serving a gatekeeping function to such high-cost services as inpatient care and nonemergency use of emergency rooms. Contracting physicians are typically paid a prospective rate, capitated for different subpopulations as defined by such actuarial variables as age, sex, and category of welfare eligibility.

Between October 1, 1981 and May 1, 1983, 53 requests for the "freedom of choice" waiver necessary for the implementation of a case management system were filed with the Department of Health and Human Services. Of these, 29 have been approved, and 8 are pending.

Examples of States developing prospectively paid case management systems include California, Colorado, Michigan, and Tennessee.

1. California

Monterey County has developed a countywide primary care network that includes all Medi-Cal eligibles living in the county. To encourage cost containment, a special budget account is created for each primary care physician. For each beneficiary who has chosen that particular physician, an amount is paid into that budget account each month. The specific amount represents the average per capita expense for a beneficiary, standardized by actuarial variables. The plan further adjusts expectations of expense or allocations to budget accounts in which a severity bias is discernable.

All claims (hospital, specialist, ancillary service expense, prescriptions) are charged against the budget account of the primary physician.

The financial risk associated with the variability of incidence and severity of illness is pooled among all participating physicians' budget accounts.

Physicians with surplus budget accounts can receive, as a bonus, an amount equal to the net surplus remaining in their budget account (after a risk-pool assessment) multiplied by an adjustment for their level of risk. Although this bonus is limited to an amount sufficient to cover the difference in reimbursement between medicaid (Medi-Cal) payments and customary fees in the community for those services, it is intended to encourage physicians' participation.

Any remaining surplus balances within each budget account are carried forward to be used to offset deficits in that budget account in the subsequent year or to be merged with any subsequent surplus in calculating the bonus payment entitlement for that physician's budget account.

Santa Barbara has developed the Santa Barbara County Special Health Care Authority as an independent public agency to assume all responsibility for the Medi-Cal program in the county. With the exception of emergency services, any health care provider wishing to receive payments for services rendered to Medi-Cal beneficiaries can do so only by contracting with the authority. Primary care and specialty physicians may contract with the authority either individually or as formal groups known as service contracting entities (SCE).

A rather complex method has been developed for determining reimbursement for contracting providers. First, the State's payment to the authority will be based on a monthly per capita calculation. Projected expenditures in the Medi-Cal program in Santa Barbara County are converted into rates per beneficiary (which vary by aid category) per month. The State then prepays to the authority a sum each month based on the number of eligible beneficiaries in each Medi-Cal aid category for that month, multiplied by the rate for that particular aid catetory.

Based on this capitation rate, the authority will actuarially allocate amounts to necessary reserves and to specific types of services.

The authority will retain a reserve pool in order to protect against unanticipated losses. In addition, the State limits the risk of providers and the authority to a maximum of $15,000 of expenses per beneficiary per contract year.

Payments to providers can be made in two ways: (1) The authority can retain the aggregate capitation payments for non-case-managed beneficiaries (these are high risk beneficiaries). All contracted providers may render services to this class of beneficiary after receiving authorization from SBHA, and are reimbursed at prevailing Medi-Cal fee-for-service rates; (2) the majority of beneficiaries are case managed by a primary care physician or an SCE. Payments are made to providers by allocating service capitation rates to individual primary care physicians and SCE accounts according to the number of case-managed beneficiaries in each practice.

The authority has also created an account for each primary care physician contracting with the authority to encourage full participation. Each month the authority credits the account with the full capitation amount and pays a portion of it as guaranteed payment. This "up front" compensation is made regardless of whether the beneficiaries in the primary care physician's practice use any services in any particular month.

Hospitals in the county will participate in the program by signing contracts with the authority. Based on previous Medi-Cal costs and utilization experience, prospective rates are set as all-inclusive per diem amounts. Each hospital receives monthly advanced payments in the form of a block payment. Block payment amounts are recalculated each month, depending on the previous month's experience. Payments are made to hospitals only for services authorized by the primary care physician and rendered to case-managed beneficiaries and are charged against the appropriate physician and SCE accounts.

2. Colorado

Colorado is currently in the early stages of implementing a primary care physician program PCPP. In addition to creating a primary care network, this program adds an additional incentive to encourage physician participation through the creation of an "incentive pool" to be added to the physician line item in the 1983–84 medicaid budget. These dollars are to be used to increase physician reimbursement under medicaid *prior* to payment of the prospective rate.

3. Michigan

A physician primary sponsor plan has recently been implemented in Wayne County. In this approach, physicians and HMO's are placed under contract to serve both as case manager and primary medical provider for medicaid recipients. Each contracting case manager is placed at risk for the cost of all services directly provided or authorized for each enrolled recipient. Although initial beneficiary response has not been as positive as wished, methods for allowing enrollees more flexibility in selecting a case manager are currently being explored.

4. Tennessee

Tennessee has developed a statewide primary care network through a contract with the Tennessee Association of Primary Health Care Centers (TAPHCC). The TAPHCC has the responsibility for developing a series of subcontracts for the provision of medicaid services to qualified individuals with the 22-member health care centers and private providers.

All community primary health care centers and primary health care physicians are eligible to participate in the PCN. The primary care providers will deliver primary services and authorize all other medical services covered by the plan except for emergency cases.

Participating providers will be at financial risk through the payment of capitated service rates.

E. CONCLUSION

Hospital care is expensive and not easily subjected to cost containment. Decisions to confront the hospital industry with clear strategies to alter its basic financing mechanism is a bold and significant event.

Through the many methods described in this paper, State governments are working toward structural reforms that hold real promise for controlling the grants in hospital expenditures. Such reforms may both reduce the rate of increase of hospital expenditures and also realize real dollar savings. In design and methodology, these programs reflect the wide diversity of options for constraining the ever-increasing costs of health care.

APPENDIX

MEDICAID HOSPITAL REIMBURSEMENT

(As of July, 1983)

STATE	Medicare Principles	Alternative Payment Systems				Expected Changes in 1984
		Medicaid Only			Multiple Payer	
		Prosp. Rate Setting	Rate of increase control	Other		
Alabama		X[1]				
Alaska	X					
Arizona				X[4]		
Arkansas	X			X[5]		
California						
Colorado			X[1]			
Connecticut	X					
Deleware	X					
Florida			X[1]			
Georgia		X[2]				
Hawaii	X					
Idaho			X[3]			
Illinois		X[1]				
Indiana	X					
Iowa		X[1]				
Kansas	X					
Kentucky			X[1]			
Louisiana	X					
Maine	X					X[12]
Maryland					X[6]	
Massachuttes					X[4]	
Michigan			X[1]			
Minnesota	X					
Mississippi		X[1]				
Missouri		X[1]				
Montana	X					

STATE	Medicare Principles	Alternative Payment Systems: Medicaid Only: Prosp. Rate Setting	Medicaid Only: Rate of Increase control	Medicaid Only: Other	Multiple Payer	Expected Changes in 1984
Nebraska		X[1]				
Nevada	X					
New Hampshire	X					
New Jersey					X[8]	
New Mexico	X					
New York					X[9]	
North Carolina		X[1]				
North Dakota	X					
Ohio	X					
Oklahoma		X[1]				
Oregon	X					
Pennsylvania	X					X[13]
Rhode Island					X[10]	
South Carolina	X					
South Dakota	X					
Tennessee	X					
Texas	X					
Utah			X[2]			X[14]
Vermont	X					
Virginia		X[1]				
Washington					X	
West Virginia	X					X[15]
Wisconsin			X[2]			X[16]
Wyoming	X					
District of Columbia	X					
TOTAL	26	10	7	2	6	

FOOTNOTES

1. Per diem
2. Per discharge
3. Per admission
4. Negotiation/Per discharge
5. Negotiation/Per diem
6. Budget/Rate review and approval (all payer system)
7. Budget/Revenue limits (all payer system)
8. Budget/Rate review and Approval/Rate per case (all payer)
9. Prospective cap on revenues (all payer system)
10. Negotiated "Maxi-Cap" -- statewide percentage revenue limit increase
11. Budget/Rate review and approval
12. In 1983 Maine established a Health Care Finance Commission empowered to implement a mandatory, all payer prospective rate setting program. The law authorizes the Commission to seek a waiver for Medicare participation in the system.
13. Pennsylvania is considering implementing a prospective reimbursement system for Medicaid only, based upon diagnosis related groups.
14. Utah is considering adopting a DRG methodology to its alternative payment system for Medicaid.
15. In 1983 West Virginia created a Health Care Cost Review Authority to implement a mandatory, all payer rate setting program by mid-1984. A waiver for Medicare participation has not been granted as yet.
16. In 1983 Wisconsin modified its program by creating a mandatory all payer rate-setting program to be administered by a three member commission. The program is to be fully implemented by January 1, 1985. The law specifically prohibits the commission from using a case-mix methodology, such as DRGs, until January 1, 1987.

Source: Intergovernmental Health Policy Project and Office of Reimbursement Policy, Health Care Financing Administration, DHHS.

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